Virginia Department of Health Professions
Board of Pharmacy

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APPLICATION FOR REGISTRATION AS A
LIMITED-USE PHARMACY TECHNICIAN
For use exclusively in a free clinic

INSTRUCTIONS

1. Applicants must complete all sections.
2. Completed application and fee must be mailed to the above address.

I. GENERAL INFORMATION

Name: Last	First			Middle/Maiden
Street Address (official address of record**)	City	State	Zip Code	Telephone Number
Street Address (public address of record)	City	State	Zip Code	Telephone Number
Date of Birth ____ ____ / ____ ____ / ____ ____ ____ ____	**Social Security Number or Virginia DMV Control Number**			
Email Address	NABP E-Profile ID Number			

**In accordance with § 54.1-2400.02 of the Code of Virginia, an applicant must provide an official address of record. An applicant may choose to provide a second address for public dissemination, which may be a work address, a post office box, or a home address. If an applicant does not provide a second address, his official address of record shall also be used as the public address for the purpose of public dissemination.

II. EITHER 1. PTCB CERTIFICATION OR 2a. and 2b. BOARD APPROVED PROGRAM INFORMATION

1) Certification from Pharmacy Technician Certification Board (PTCB)	YES ☐ Number: _____Exp Date: _____	NO ☐
OR		
2a) Completion of Board Approved Training Program **AND**	YES ☐ **Copy of certificate of completion of a Board-approved training program must accompany this application**	NO ☐
2b) ExCPT examination (NHA Certification)	YES ☐ **NHA Certification Number:** _____ **Expiration Date**: _____	NO ☐

FOR OFFICE USE ONLY

Application Number	Registration Number	Date Issued	Other
02_____	0231_____		

III. ADDITIONAL LICENSURE, CERTIFICATION, OR REGISTRATION: List all states or other jurisdictions in which you now hold or have ever held a license, certification or registration as a pharmacy technician (use extra paper if necessary).

STATE	NUMBER	EXPIRATION DATE

IV. ANSWER THE FOLLOWING QUESTIONS: Attach additional page if needed as well as any related documents

		YES	NO
1.	Have you ever been denied a pharmacy technician license, certification, or registration? **If yes, state where, explain the reason, and attach any related document**s:	☐	☐
2.	Have you ever had disciplinary action against your pharmacy technician license, certification, or registration in any other jurisdiction, or have been prohibited from performing the duties of a pharmacy technician by any other state, or prohibited by a health regulatory board of any state or by any federal agency from practicing, or assisting in the practice of, any health profession? **If yes, what jurisdiction and date, explain, and attach any official documents related to your case.**	☐	☐
3.	Have you ever been convicted of, pled *nolo contendere* to, or have charges pending of any felony, or any crime involving moral turpitude, or a violation of any federal, state, or local drug law? **If yes, what jurisdiction and date where charged or convicted, explain, and attach copies of any official documents such as warrants and court orders showing the nature and disposition of such charges or convictions.**	☐	☐
4.	Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? **If yes, provide full explanation including if you have been directed to seek treatment for your conduct or behavior.**	☐	☐
5.	Within the past five years, have you been disciplined by any entity? **If yes, please provide a full explanation and any associated orders or letters from entity.**	☐	☐
6.	Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Pharmacy Technician. **If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board.**	☐	☐

		YES	NO
7.	Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Pharmacy Technician. **If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board.**	☐	☐
8.	Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Pharmacy Technician? **If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board**	☐	☐
9.	Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? **If yes, please provide a full explanation and any associated orders or letters from the entity. NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider requesting your provider send this documentation directly to the Board.**	☐	☐
10.	Are you a spouse of someone who is on federal active duty orders pursuant to Title 10 of the U. S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia?	☐	☐
11.	Are you active duty military?	☐	☐

V. APPLICANT'S STATEMENT (The following statement must be signed)

I, _____ hereby certify and affirm that the statements contained
(Print Name)

in this application for registration as a pharmacy technician in the Commonwealth of Virginia are true and accurate in every respect. I hereby make application for registration as a **Limited-Use Pharmacy Technician** in the Commonwealth of Virginia. The following evidence of my qualifications is submitted. I understand that I may not work as a pharmacy technician in a pharmacy other than a free clinic pharmacy with this limited registration.

Signature of applicant	Date